	FO	R BHF	USE		

LL1

2013 STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2013)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

IDPH Licer		1433 Reh		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
Address: County: Telephone HFS ID Nu	1517 West Walnut Number Morgan Number: (217) 243-6451	Jacksonville City Fax # (217) 243-8295	62650 Zip Code	State o and cer are true applica is base Inter	re examined the contents of the accompanying report to the fillinois, for the period from 01/01/13 to 12/31/13 tify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider) d on all information of which preparer has any knowledge. Intional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
Type of Ow	tial License for Current Owners: vnership: DLUNTARY,NON-PROFIT Charitable Corp.	X PROPRIETARY Individual	GOVERNMENTAL State	Officer or Administrator of Provider	(Signed)(Date) (Type or Print Name) (Title)
IRS Exemp	Trust ption Code	Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other	County Other	Paid Preparer	(Signed) (Date) (Print Name and Title) (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
	nt there are further questions about eve Lavenda	this report, please contact: Telephone Number: (847) 236- Email Address:	1111		(Telephone)

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numl	ber Jacksonville	Skld Nur & Reh				# 0051433 Report Period Beginning: 01/01/13 Ending: 12/31/13
	III. STATISTICA	AL DATA					D. How many bed-hold days during this year were paid by the Department?
	A. Licensure/	certification level(s) o	of care; enter numbe	er of beds/bed days,			None (Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	f change in licensed	beds	N/A		
	, ,	,	, and the second				E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensu	ıre	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes
	Report Period	Level of	_	Report Period	Report Period		
	Tepore remou	Ecveror	Cure	Troport I criou	Troport I criou		G. Do pages 3 & 4 include expenses for services or
1	61	Skilled (SN	F)	61	22,265	1	investments not directly related to patient care?
2	VI		iatric (SNF/PED)	01	22,203	2	YES NO X
3	27	Intermedia		27	9,855	3	
4		Intermedia			7,000	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C				5	YES NO X
6		ICF/DD 16	` ′			6	
							I. On what date did you start providing long term care at this location?
7	88	TOTALS		88	32,120	7	Date started5/1/2011
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report pe	riod.				YES X Date <u>5/1/2011</u> NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	nd Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Medicaid					YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 61 and days of care provided 5,004
8	SNF	7,525	6,535	5,208	19,268	8	
9	SNF/PED					9	Medicare Intermediary National Government Services
	ICF	6,954	2,831		9,785	10	
	ICF/DD					11	IV. ACCOUNTING BASIS
-	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	14,479	9,366	5,208	29,053	14	Is your fiscal year identical to your tax year? YES X NO
	C Damant O	annamar (Cal	line 14 dissided by 4	otal ligange d			Tor Vocas 12/21/2012 Final Vocas 12/21/2012
		ccupancy. (Column 5, n line 7, column 4.)	, iine 14 aividea by t 90.45%	otai ncenseu			Tax Year: 12/31/2013 Fiscal Year: 12/31/2013 * All facilities other than governmental must report on the accrual basis.
	Deu days of	11 11110 7, COIUIIII 4.)	70.73 /0	_	SEE ACCOUNTAI	NTS' CO	OMPILATION REPORT

	Facility Name & ID Number	Jacksonville Sk			STATE OF ILI	AINOIS 0051433	Report Period	l Beginning:	01/01/13	Ending:	Page 3 12/31/13	_
	V. COST CENTER EXPENSES (through	ghout the report.	<u>, please round to</u> osts Per Genera	<u>) the nearest d</u>	ollar)	Reclass-	Reclassified	Adjust-	Adjusted	FOR RHE	USE ONLY	$\overline{}$
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	TOK BIII	OSE ONET	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	115,584	11,051	8,876	135,511	-	135,511		135,511	-		1
2	Food Purchase	,	136,579	,	136,579		136,579	(440)	136,139			2
3	Housekeeping	59,849	15,112	2,273	77,234		77,234	` /	77,234			3
4	Laundry	32,945	7,187		40,132		40,132		40,132			4
5	Heat and Other Utilities			77,375	77,375		77,375	(10,145)	67,230			5
6	Maintenance	25,955	10,834	42,653	79,442		79,442	14,785	94,227			6
7	Other (specify):*			·					•			7
8	TOTAL General Services	234,333	180,763	131,177	546,273		546,273	4,200	550,473			8
	B. Health Care and Programs	Í	ĺ	, i	,							
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,459,857	71,893	6,014	1,537,764		1,537,764	(20,621)	1,517,143			10
10a	Therapy	40,218	19,687	·	59,905		59,905	, , ,	59,905			10a
11	Activities	47,468	2,874	3,087	53,429		53,429		53,429			11
12	Social Services	67,140	268	2,712	70,120		70,120		70,120			12
13	CNA Training											13
14	Program Transportation			1,064	1,064		1,064		1,064			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,614,683	94,722	24,877	1,734,282		1,734,282	(20,621)	1,713,661			16
	C. General Administration											
17	Administrative	84,989		179,610	264,599		264,599	6,012	270,611			17
18	Directors Fees											18
19	Professional Services			19,477	19,477		19,477	39,762	59,239			19
20	Dues, Fees, Subscriptions & Promotions			47,105	47,105		47,105	(38,511)	8,594			20
21	Clerical & General Office Expenses	106,073	14,584	100,761	221,418		221,418	(83,576)	137,842			21
22	Employee Benefits & Payroll Taxes			379,871	379,871		379,871	20,540	400,411			22
23	Inservice Training & Education											23
24	Travel and Seminar			105	105		105	26,317	26,422			24
25	Other Admin. Staff Transportation			14,245	14,245		14,245	(1,050)	13,195			25
26	Insurance-Prop.Liab.Malpractice			155,458	155,458		155,458	2,669	158,127			26
27	Other (specify):*							44,362	44,362			27
28	TOTAL General Administration	191,062	14,584	896,632	1,102,278		1,102,278	16,525	1,118,803			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,040,078	290,069	1,052,686	3,382,833		3,382,833	104	3,382,937			29
	10 man 01 111100 01 10 00 #U							ANTSLCOMDII		TF.		

29 | Coum of lines 8, 16 & 28) | 2,040,078 | 290,069 | 1,052,686 | 3,382,833 | 3,382,833 | 3,382,833 | 104 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. | SEE ACCOUNTANTS' COMPILAT NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification. SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99) IL478-2471 Jacksonville Skld Nur & Reh

Report Period Beginning:

01/01/13

Ending:

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V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF	FOR BHF USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			100,717	100,717		100,717	(60,694)	40,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							4,056	4,056			32
33	Real Estate Taxes			(45,736)	(45,736)		(45,736)	79,658	33,922			33
34	Rent-Facility & Grounds			308,821	308,821		308,821		308,821			34
35	Rent-Equipment & Vehicles			16,182	16,182		16,182		16,182			35
36	Other (specify):*							20,908	20,908			36
37	TOTAL Ownership			379,984	379,984		379,984	43,928	423,912			37
	Ancillary Expense											
	E. Special Cost Centers											
38												38
39	Ancillary Service Centers		158,710	801,126	959,836		959,836	(28,233)	931,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,157	194,157		194,157		194,157			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		158,710	995,283	1,153,993		1,153,993	(28,233)	1,125,760			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,040,078	448,779	2,427,953	4,916,810		4,916,810	15,799	4,932,609			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

0051433 Report Period Beginning:

01/01/13

Ending: 12

Page 5 12/31/13

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Til Columi	ii Z Delow,	1	ine on w	hich the particu	iar cos
			1	Refer-	BHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms		(10,145)	05		5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		(60,694)	30		9
10	Interest and Other Investment Income		(7,272)	32		10
11	Discounts, Allowances, Rebates & Refunds		() ,			11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(440)	02		13
14	Non-Care Related Interest		(/			14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(87,746)	21		24
25	Fund Raising, Advertising and Promotional		(37,862)	20		25
	Income Taxes and Illinois Personal		` ' /			1
26	Property Replacement Tax					26
27	CNA Training for Non-Employees					27
28	Yellow Page Advertising					28
29	Other-Attach Schedule		81,501			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(122,658)		\$	30

B. If there are expenses experienced by the facility which	do not ap	pear in the
general ledger, they should be entered below.(See instr	uctions.)	
	1	2

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	138,457	'	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 138,457	'	36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 15,799)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

1 2 3

(Sc	ee instructions.)	1	2	3		4	
		Yes	No	Amo	unt	Reference	
38	Medically Necessary Transport.			\$			38
39							39
40	Gift and Coffee Shops						40
41	Barber and Beauty Shops						41
42	Laboratory and Radiology						42
43	Prescription Drugs						43
44							44
45	Other-Attach Schedule						45
46	Other-Attach Schedule						46
47	TOTAL (C): (sum of lines 38-46)	•		\$			47

	BHF USE ONL	Y					
48		49	5	0	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Jacksonville Skld Nur & Reh

ID#	0051433
Report Period Beginning:	01/01/13
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Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
				1
1	Additional R&M	\$ 12,960	06	1
2	Underaccrual of Incentive Bonuses	20,540		2
3	Non Allowable Dues	(1,049)		3
4	Bank Charges	(335)		4
5	Business Taxes	(671)	_	5
6	Donations	(250)	_	6
7	PPA - Medical Expenses	(20,571)	10	7
8	Personal Items	(50)		8
9	Non Allowable Travel	(1,050)	25	9
10	Real Estate Taxes	79,658	33	10
11	PPA-Professional Fees	(356)	19	11
12	PPA-Misc. Expenses	(7,325)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	81,501	49

STATE OF ILLINOIS

Page 5B

Jacksonville Skld Nur & Reh

ID#	0051433
Report Period Beginning:	01/01/13
Ending:	12/31/13

Sch. V Line

			Sch. v Line					
	NON-ALLOWABLE EXPENSES	Amount	Reference					
50		\$		1				
51				2				
52				3				
53				4				
54				5				
55				6				
56				7				
57				8				
58				9				
59				10				
60				11				
61				12				
62				13				
63				14				
64				15				
65				16				
66				17				
67				18				
68				19				
69				20				
70				21				
71				22				
72				23				
73				24				
74				25				
75				26				
76				27				
77				28				
78				29				
79				30				
80				31				
81				32				

82		33	1
83		34	1
84		35	
85		36	
86		37	
87		38	
88		39	
89		40	
90		41	
91		42	
92		43	
93		44	
94		45	
95		46	
96		47	
97		48	
98	Total 0	49]

STATE OF ILLINOIS Summary A

0051433 Report Period Beginning: 12/31/13 01/01/13 Facility Name & ID Number Jacksonville Skld Nur & Reh **Ending:** SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6L

SUMMARY OF PAGES 5, 5A, 6, 62												SUMMARY	
Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6Н	6 I	(to Sch V, col	1.7)
1 Dietary													1
2 Food Purchase	(440)											(440)	2
3 Housekeeping													3
4 Laundry													4
5 Heat and Other Utilities	(10,145)											(10,145)	
6 Maintenance	12,960			1,825								14,785	6
7 Other (specify):*													7
8 TOTAL General Services	2,375			1,825								4,200	8
B. Health Care and Programs													
9 Medical Director													9
10 Nursing and Medical Records	(20,621)											(20,621)	10
10a Therapy													10
11 Activities													11
12 Social Services													12
13 CNA Training													1.
14 Program Transportation													1
15 Other (specify):*													1:
16 TOTAL Health Care and Programs	(20,621)											(20,621)	10
C. General Administration													
17 Administrative				6,012								6,012	1
18 Directors Fees													13
19 Professional Services	(356)			40,118								39,762	19
20 Fees, Subscriptions & Promotions	(39,161)			650								(38,511)	
21 Clerical & General Office Expenses	(96,077)			12,501								(83,576)	
22 Employee Benefits & Payroll Taxes	20,540											20,540	2
23 Inservice Training & Education													2.
24 Travel and Seminar				26,317								26,317	2
25 Other Admin. Staff Transportation	(1,050)											(1,050)	2
26 Insurance-Prop.Liab.Malpractice				2,669								2,669	2
27 Other (specify):*				44,362								44,362	2
28 TOTAL General Administration	(116,104)			132,629								16,525	2
TOTAL Operating Expense											_		
29 (sum of lines 8,16 & 28)	(134,350)			134,454								104	2

STATE OF ILLINOIS

Summary B # 0051433 12/31/13 **Facility Name & ID Number Report Period Beginning:** 01/01/13 Ending: Jacksonville Skld Nur & Reh

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6 B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	.7)
30	Depreciation	(60,694)											(60,694)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,272)			11,328								4,056	32
33	Real Estate Taxes	79,658											79,658	33
	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*				20,908								20,908	36
37	TOTAL Ownership	11,692			32,236								43,928	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(28,233)									(28,233)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers			(28,233)									(28,233)	44
	GRAND TOTAL COST				_					_				
45	(sum of lines 29, 37 & 44)	(122,658)		(28,233)	166,690								15,799	45

HFS 3745 (N-4-99) IL478-2471

#

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0051433

Report Period Beginning:

Ending:

12/31/13

VII. RELATED PARTIES

Facility Name & ID Number

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

Enter below the harnes of ALL owners and related organizations (parties) as defined in the metabolic region of approximation of the residual of the second o									
1		2 RELATED NURSING HOMES			3				
OWNERS					OTHE	R RELA	TED BUSINES	S ENTITI	ES
Name	Ownership %	Name	City		Name		City		Type of Business
See Page 6 Supplemental		See Page 6 Supplemental			See Page 6 Sup	plementa	al		
					•				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES X NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scl	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12									12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99) IL478-2471

0051433

12/31/13

VII. RELATED PARTIES	(continued)
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В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent,
	management fees, purchase of supplies, and so forth.	X	YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	the mstru	CHOHS	or determining costs as specified for	tills for ill.				
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
					_	Ownership	Organization	Costs (7 minus 4)
15	V	39	Physical Therapy	\$ 304,882	Select Therapy	100.00%	293,327	
16	V	39	Occupational Therapy	302,379	Select Therapy	100.00%	290,919	(11,460) 16
17	V	39	Speech Therapy	137,676	Select Therapy	100.00%	132,458	(5,218) 17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total			\$ 744,937			\$ 716,704	\$ * (28,233) 39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

#	0051433
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Report Period Beginning:

01/01/13

Ending: 12/31/13

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scho	Schedule V Line Item		Item	Amount	Name of Related Organization	of	of Related	Related Organization	1
						Ownership	Organization	Costs (7 minus 4)	
15	V	36	Building, Fixture, Equipment	\$	Covenant Care, Inc.	100.00%			15
16	V	06	Repairs & Maintenance		Covenant Care, Inc.	100.00%	1,825	1,825	16
17	V	17	Administrative		Covenant Care, Inc.	100.00%	185,622	185,622	17
18	V	19	Professional Services		Covenant Care, Inc.	100.00%	40,118	40,118	18
19	V		Dues & Subscriptions		Covenant Care, Inc.	100.00%	650	650	19
20	V	21	Clerical/Office		Covenant Care, Inc.	100.00%	12,501	12,501	20
21	V	24	Seminar		Covenant Care, Inc.	100.00%	26,317	26,317	21
22	V	26	Insurance		Covenant Care, Inc.	100.00%	2,669	2,669	22
23	V		Employee Benefits		Covenant Care, Inc.	100.00%	44,362	44,362	23
24	V	32	Interest		Covenant Care, Inc.	100.00%	11,328	11,328	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V	17	Management Fees	179,610	Covenant Care, Inc.	100.00%		(179,610)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 179,610			\$ 346,300	\$ * 166,690	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jacksonville Skld Nur & Reh 0051433 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

VII. RELATED PARTIES (c	continued)
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В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	the instructions for determining costs as specified for this form. 1								
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization		of Related	Related Organization	ı
					0		Organization	Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Jacksonville Skld Nur & Reh # 0051433 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES	(continued)
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В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		8		8	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Teem	Timount	Traine of Related Organization	Ownership	Organization	Costs (7 minus 4)	
15 V			•			© Organization		15
16 V			3			3	3	16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V 35 V								34
00								35
								36 37
37 V 38 V								38
39 Total			\$			 \$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

acksor	ville	Skld	Nur	æ	Reh	

#	M)51	43	3
π	v	$\boldsymbol{\omega}$	TJ	J

Report Period Beginning:

12/31/13

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wi	ith related organizati	ions? '	This includes rent
	management fees, purchase of supplies, and so forth.	YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		8		8	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Teem	Timount	Traine of Related Organization	Ownership	Organization	Costs (7 minus 4)	
15 V			•			© Organization		15
16 V			3			3	3	16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V 35 V								34
00								35
								36 37
37 V 38 V								38
39 Total			\$			 \$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Jackson	ville	Skld	Nur	æ	Re

#	α	\ = 1	1433
ш.		-	141

Report Period Beginning:

12/31/13

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	<u>h rela</u> ted organiz	at <u>ions?</u>	This includes re	ent
	management fees nurchase of supplies, and so forth	VES		NO	

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	the msu t		or determining costs as specified for		T	1	Г	T	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ı
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (c	continued)
-------------------------	------------

В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		8		8	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Teem	Timount	Traine of Related Organization	Ownership	Organization	Costs (7 minus 4)	
15 V			•		Ownership	© Organization		15
16 V			3			3	3	16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V 35 V								34
00								35
								36 37
37 V 38 V								38
39 Total			\$			 \$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII.	REL	ATED	PARTIES	(continued)
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В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	[2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			3			Percent	Operating Cost	Adjustments for	
Sched	lule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
Senec	iuic v	Line	Tem	rimount	Traine of Related Organization	Ownership			•
15	V	1		•			Organization \$	Costs (7 minus 4)	15
16	V			3			3	3	15 16
17	V	1							17
18	V	1							18
19	V								19
20	V								20
21	V								21
22	V	1							22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V		_						34
35	V								35
36	V								36
37	V								37
38	V						_		38
39	Fotal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

0051433

VII. RELATED PARTIES (continued)

Facility Name & ID Number

B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	[2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			3			Percent	Operating Cost	Adjustments for	
Sched	lule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
Senec	iuic v	Line	Tem	rimount	Traine of Related Organization	Ownership			•
15	V	1		•			Organization \$	Costs (7 minus 4)	15
16	V			3			3	3	15 16
17	V	1							17
18	V	1							18
19	V								19
20	V								20
21	V								21
22	V	1							22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V		_						34
35	V								35
36	V								36
37	V								37
38	V						_		38
39	Fotal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Jacksonville Skld Nur & Reh

0051433

Report Period Beginning:

01/01/13 Ending:

12/31/13

VII. RELATED PARTIES

Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. A. (Continued)

	1		2			3		
	OWNERS		RELATED NURSING HO	OMES	OTHER RE	CLATED BUSINESS	ENTITIES	
	Name	Ownership %	Name	City	Name	City	Type of Business	1
1	COVENANT CARE, INC.	100.000%	ARBOR NURSING CENTER	CALIFORNIA	COVENANT CARE, INC.	ALISO VIEJO, CA	MANAGEMANT CO.	1
2			ARBOR PLACE	CALIFORNIA	SELECT THERAPY	ALISO VIEJO, CA	THERAPY	2
3			BUENA VISTA CARE CENTER, A NURSING & REHAB FACILITY	CALIFORNIA				3
4			CARSON NURSING & REHAB CENTER	NEVADA				4
5			CATERED MANOR	CALIFORNIA				5
6			CLINTON HOUSE HEALTH & REHABILITATION CENTER	INDIANA				6
7			COURTYARD HEALTHCARE CENTER	CALIFORNIA				7
8			COVENANT CARE HILLTOP,LLC D/B/A HILLTOP SKILLED NSG	& 1 CHARLESTON				8
9			COVENANT CARE JACKSONVILLE,LLC□ D/B/A JACKSONVILLI	E SI JACKSONVILLE				9
10			COVENANT CARE MEADOW MANOR,LLC□ D/B/A MEADOW MA	ANC TAYLORVILLE				10
11			COVENANT CARE MIDWEST, INC. D/B/A CEDAR RIDGE HEALT	H & LEBANON				11
12			COVENANT CARE SUNRISE,LLC D/B/A SUNRISE SKILLED NURS	SINCVIRDEN				12
13			COVINGTON MANOR	INDIANA				13
14			DOWNEY CARE	CALIFORNIA				14
15			EAGLE POINT NUSING AND REHAB CENTER	IOWA				15
16			EDGEWOOD MANOR NURSING CENTER	ОНЮ				16
17			EMERALD GARDENS NURSING CENTER	CALIFORNIA				17
18			ENCINITAS NURSING AND REHABILITATION CENTER	CALIFORNIA				18
19			ENNOBLE SKILLED NURSING & REHAB CENTER	IOWA				19
20			FAIRVIEW MANOR NURSING CENTER	ОНЮ				20
21			FRIENDSHIP HOME	CARLINVILLE, IL				21
22			GILROY HEALTHCARE & REHABILITATION CENTER	CALIFORNIA				22
23			GRANT CUESTA NURSING & REHABILITATION CENTER	CALIFORNIA				23
24			HIGHLAND HEALTH CARE CENTER	ILLINOIS				24
25			HUNTINGTON PARK NURSING CENTER	CALIFORNIA				25
26			LA JOLLA NURSING AND REHABILITATION CENTER	CALIFORNIA				26
27			LAKELAND NURSING CENTER	INDIANA				27
28			LOS ALTOS SUB-ACUTE & REHABILITATION CENTER	CALIFORNIA				28
29			MISSION SKILLED NURSING & SUBACUTE CENTER	CALIFORNIA				29
30			NEBRASKA SKILLED NURSING CENTER	NEBRASKA				30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Jacksonville Skld Nur & Reh

0051433

Report Period Beginning:

01/01/13 Ending:

12/31/13

VII. RELATED PARTIES

Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. A. (Continued)

7x. (Continued)	1		,		3		
	OWNERS	RELATED NURSING HO	OMES	OTHER	RELATED BUSINESS	SENTITIES	
Name	Ownership %	Name	City	Name	City	Type of Business	1 1
1		NORWOOD NURSING CENTER	INDIANA				1
2		PACIFIC COAST MANOR	CALIFORNIA				2
3		PACIFIC GARDENS NURSING & REHABILITATION CENTER	CALIFORNIA				3
4		PACIFIC HILLS MANOR	CALIFORNIA				4
5	<u> </u>	PALO ALTO NURSING CENTER	CALIFORNIA				5
6		ROYAL CARE SKILLED NURSING CENTER	CALIFORNIA				6
7		SHORELINE CARE CENTER	CALIFORNIA				7
8		SILVER HILLS HEALTH CARE CENTER	NEVADA				8
9		SILVER RIDGE HEALTHCARE CENTER	NEVADA				9
10		ST. EDNA SUBACUTE & REHABILITATION CENTER	CALIFORNIA				10
11		THE RESIDENCE AT MCCORMICK'S CREEK	INDIANA				11
12		TURLOCK NURSING AND REHABILITATION CENTER	CALIFORNIA				12
13		TURLOCK RESIDENTIAL	CALIFORNIA				13
14		UNIVERSITY PARK NURSING CENTER	INDIANA				14
15		VALLE VISTA CONVALESCENT CENTER	CALIFORNIA				15
16		VERSAILLES HEALTH CARE CENTER	ОНЮ				16
17		VILLA GEORGETOWN	ОНЮ				17
18		VILLA SPRINGFIELD	ОНЮ				18
19		VINTAGE FAIRE NURSING & REHABILITATION CENTER	CALIFORNIA				19
20		VINTAGE FAIRE RESIDENTIAL	CALIFORNIA				20
21		WAGNER HEIGHTS NURSING & REHABILITATION CENTER	CALIFORNIA				21
22		WAGNER HEIGHTS RESIDENTIAL	CALIFORNIA				22
23		WALDRON HEALTH AND REHAB CENTER	INDIANA				23
24		WILLOW TREE NURSING & REHABILITATION CENTER	CALIFORNIA				24
25		WRIGHT NURSING & REHAB CENTER (VILLA FAIRBORN)	ОНЮ				25
26		MARION REHAB AND ASSISTED LIVING CENTER	INDIANA				26
27		PYRAMID POINT POST ACUTE REHABILITATION CENTER	INDIANA				27
28							28
29							29
30							30

SEE ACCOUNTANTS' COMPILATION REPORT

0051433 Report Period Beginning:

01/01/13

Ending:

12/31/13

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensati	on Included	Schedule V.	
					Received		l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

		STATE OF ILLINOIS	1 age o
Facility Name & ID Number	Jacksonville Skld Nur & Reh	# 0051433 Report Period Beginning: 01/01/13 Ending: 1	2/31/13

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO X	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	11010101100		zquare recey	1000101100		\$	\$	0 11105	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12 13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23	_				_					23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Page 8A Facility Name & ID Number # 0051433 Report Period Beginning: Jacksonville Skld Nur & Reh 01/01/13 **Ending:** 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Select Therapy
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	27071 Aliso Creek Road
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Aliso Viejo, CA 92656
	Phone Number	(949)349-1200
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	949)349-1900

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	39	Physical Therapy	Direct Allocation		J	\$	\$		\$ 293,327	1
2	39	Occupational Therapy	Direct Allocation						290,919	2
3	39	Speech Therapy	Direct Allocation						132,458	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
	TOTALS					S			\$ 716,704	24 25

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99) IL478-2471 # 0051433 Report Period Beginning:

01/01/13

Ending: 12/31/13

STATE OF ILLINOIS Page 8B

VIII. ALLOCATION OF INDIRECT COSTS

Facility Name & ID Number

	Name of Related Organization	Covenant Care, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	27071 Aliso Creek Rd
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Aliso Viejo, CA 92656
	Phone Number	949)349-1200
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	949)349-1900

b. Show the anocation of costs below.	ii necessary, piease attach worksneets.

Jacksonville Skld Nur & Reh

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	36	Building, Fixture, Equipment	Accumulated Cost			\$	\$		\$ 20,908	1
2		Repairs & Maintenance	Accumulated Cost						1,825	2
3		Administrative	Accumulated Cost						185,622	3
4		Professional Services	Accumulated Cost						40,118	4
5		Dues & Subscriptions	Accumulated Cost						650	5
6	21	Clerical/Office	Accumulated Cost						12,501	6
7	24	Seminar	Accumulated Cost						26,317	7
8		Insurance	Accumulated Cost						2,669	8
9		Employee Benefits	Accumulated Cost						44,362	9
10	32	Interest	Accumulated Cost						11,328	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 346,300	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 8C STATE OF ILLINOIS

	Facility Name	e & ID Number	Jacksonville Skl	ld Nur & Reh		#0051433	Report Period Beginning:	01/01/13	Ending:	12/31/13	
		CATION OF INDIRE						ated Organization			
				hich were derived from		ral office	Street Addre				
	or pare	ent organization costs	? (See instructio	ons.) YES	NO		City / State /	Zip Code			
							Phone Numb)		
	B. Show t	he allocation of costs	below. If necess	ary, please attach worl	ksheets.		Fax Number	· <u>(</u>)		
	1	2		3	4	5	6	7	8	9	1
	Schedule V			Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		6	.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		T.	(1)	-	7D 4 1 T 1 4		- C		=		
1	Reference	Item		Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	+-
1							\$	3		3	2
3											3
4							+			+	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20 21											20
22											21
23			+								23
24											24
	TOTALS						\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99) IL478-2471

						STATE OF I	LLINOIS				Page 8D			
	Facility Name	e & ID Number	Jacksonville Skld	Nur & Reh		# 0051433	Report Period Beginning:	01/01/13	Ending:	12/31/13				
	VIII. ALLOC	CATION OF INDIR	ECT COSTS											
Name of Related Organization A Are there any costs included in this report which were derived from allocations of central office. Street Address														
A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO City / State / Zip Code														
	or pare)												
	B. Show th	he allocation of cost)											
				• • • • • • • • • • • • • • • • • • • •					,					
	1	2		3	4	5	6	7	8	9				
	Schedule V		U	Init of Allocation		Number of	Total Indirect	Amount of Salary						
	Line		(i.e.,	,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocati	on			
	Reference	Item		Square Feet)	Total Units	Allocated Amon	g Allocated	in Column 6	Units	(col.8/col.4)	x col.6			
1							\$	\$		\$		1		
2												2		
3												3		

	Schedule v		Chit of Amocation		1 valider of	Total Illuli cct	7 mount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19 20										19 20
21										21
22										22
23										23
24										24
	TOTALS					6	6		0	25
1 23	IIUIALS					I \$	\$		18	1 23

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS Page 8E

	Facility Name	e & ID Number Jacks	onville Skld Nur & Reh		# 0051433	Report Period Beginning:	01/01/13	Ending:	12/31/13	
	VIII. ALLO	CATION OF INDIRECT C	OSTS			Name of Po	ated Organization			
	A Arath	are any costs included in thi	is report which were derived fron	n allocations of cont	tral office	Street Addr			<u>.</u>	
		ent organization costs? (See				City / State			_	-
	or part	ent organization costs. (See		110		Phone Num	ber 7)	_	
	B. Show t	he allocation of costs below.	. If necessary, please attach work	ksheets.		Fax Number)		
			• • • • • • • • • • • • • • • • • • • •					,		
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		3	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11 12										11
13										12
14									_	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24				-				-		24

SEE ACCOUNTANTS' COMPILATION REPORT

25

HFS 3745 (N-4-99)

25 TOTALS

Page 8F

25

	Facility Name	e & ID Number Jack	ksonville Skld Nur & Reh		# 0051433 F	Report Period Beginning:	01/01/13	Ending:	12/31/13	
	VIII. ALLOC	CATION OF INDIRECT	COSTS			Name of Dal	ated Organization			
	A Are the	ere any costs included in t	his report which were derived fron	n allocations of cent	ral office	Street Addro				
		ent organization costs? (So		NO		City / State /			•	
	-	· ·	,			Phone Numb	oer ()	•	
	B. Show the	he allocation of costs belo	w. If necessary, please attach work	ksheets.		Fax Number)		
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
7			+							7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15 16										15 16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24	_									24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99) IL478-2471

						STATE OF I	LLINOIS			Page 8	G
	Facility Name	e & ID Number	Jacksonville S	Skld Nur & Reh		# 0051433	Report Period Beginning:	01/01/13	Ending:	12/31/13	
	VIII. ALLOC	CATION OF INDIF	RECT COSTS								
							Name of Rel	ated Organization	4		
				t which were derived from	<u>m allo</u> cations of cent	<u>ral off</u> ice	Street Addro City / State /				
	or pare	ent organization co									
	D Cl 4						Phone Numl	<u>, </u>)		
	B. Show th	ne allocation of cos	ts below. If nece	essary, please attach worl	ksheets.		Fax Number	<u>(</u>)		
	1	2		3	4	5	6	7	8	9	
	Schedule V			Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line			(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item		Square Feet)	Total Units	Allocated Amon	g Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1							\$	\$		\$	1
2											2
3											3
4											4

	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11									 	11
12									 	12
13										13
14									 	14
15									 	15
16									 	16
17									 	17
18 19									 	18 19
20									 	20
21									 	21
22										21
23										22 23
24										24
	TOTALO					0	0		6	
25	TOTALS					\$	\$		2	25

SEE ACCOUNTANTS' COMPILATION REPORT

			JIMIL OF				i age off
Facility Name & ID Number	Jacksonville Skld Nur & Reh	#	0051433	Report Period Beginning:	01/01/13	 12/31/13	

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			~ q • = • • • • •			\$	\$	0.000	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
11										10 11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	-									20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

3		Facility Name	e & ID Number Jacksonville	Skld Nur & Reh		STATE OF II # 0051433	LINOIS Report Period Beginning:	01/01/13	Ending:	Page 8I 12/31/13	
Schedule V Line Reference Item Square Feet)		A. Are the or pare	ere any costs included in this repo ent organization costs? (See instru	ections.) YES	NO	ral office	Street Addre City / State / Phone Numb	Zip Code)		
Line Reference Item		1	2	3	4	5	6	7	8	9	
Reference Item		Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
Reference Item		Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
S S S S S S S S S S S S S S S S S S S		Reference	Item		Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
3	1			1 1 1 1 1 1 1 1			\$	\$		\$	1
4	2										2
5 <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3</td>	3										3
6 6 7 6 8 6 9 7 1 1 2 1 3 1 4 1	1										4
7	5										5
3 3 0 3 1 4	6										6
0 1 1 1 2 1 3 1 4 1	7										7
0 1 1 1 2 1 3 1 4 1	3										8
1 1 2 1 3 1 4 1)										9
2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0										10
3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1										11
4 1	2										12 13
	s 1						+				13
	5										15

25 TOTALS

SEE ACCOUNTANTS' COMPILATION REPORT

Jacksonville Skld Nur & Reh

0051433

Report Period Beginning:

01/01/13 Ending:

Page 9 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
				Monthly				Maturity	Interest	Reporting Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of	Amor	ant of Note	Date	Rate	Interest	
		YES NO	-	Required	Note	Original	Balance	1	(4 Digits)	Expense	
	A. Directly Facility Related										
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6	Alloc from Covenant Care	X								11,328	6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$ 11,328	9
	B. Non-Facility Related*				1	1			1	T	
	Interest Income	X								(7,272)	
11											11
12											12
13											13
1,,	TOTAL N. P. W. P. L.						Φ.			(5.252)	
14	TOTAL Non-Facility Related	-				2	\$			\$ (7,272)	14
											_
15	TOTALS (line 9+line14)					\$	\$			\$ 4,056	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. Line # N/A

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^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number

Jacksonville Skld Nur & Reh

0051433

Report Period Beginning:

01/01/13 Ending:

1σ:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**	Purpose of Loan	Monthly Payment	Date of		int of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related										
	Long-Term						1.	1	1		
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
6											6
7	TOTAL Long-Term										7
	Working Capital			1		la.	la .	1			
8						\$	\$			\$	8
9											9
10											10
11											11
12											12
13	TOTAL IN C. I. I										13
14	TOTAL Working Capital										14
	B. Non-Facility Related*			T		I a	I.a.	T	T		
15						\$	\$			\$	15
16											16
17											17
18											18
19											19
20	TOTAL Non-Facility Related										20

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Page 10 # 0051433 Report Period Beginning: **01/01/13** Ending: 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. Important, please see the ne statement and bill must acc	xt worksheet, "RE_Tax". The real estate tax smpany the cost report.
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If	payment covers more than one year, detail below.) \$ 33,922
3. Under or (over) accrual (line 2 minus line 1).	\$ 33,922
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accru	al on the lines below.)
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees (Describe appeal cost below. Attach copies of invoices to support the cost	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal cost classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a co	by of the real estate tax appeal board's decision.)
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of line	\$ 3 thru 6. \$ 33,922
Real Estate Tax History:	
Real Estate Tax Bill for Calendar Year: 2008 28,547 8 2009 30,470 9	FOR BHF USE ONLY
2010 49,798 10	13 FROM R. E. TAX STATEMENT FOR 2012 \$
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	14 PLUS APPEAL COST FROM LINE 5 \$
Facility does not accrue for real estate taxes.	15 LESS REFUND FROM LINE 6 \$
	16 AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Jacksonville Sklo	l Nur & Reh			COUNTY M	lorgan	
FAC	ILITY IDPH LICEN	NSE NUMBER	0051433					
CON	TACT PERSON RI	EGARDING THI	S REPORT Steve Lav	enda				
TEL	EPHONE (847) 23	6-1111		FAX #: (847) 236-1	155		
A.	Summary of Real	Estate Tax Cost	<u>t</u>					
	cost that applies to home property whi	the operation of ch is vacant, rent	estate tax assessed for the nursing home in Co ed to other organization de cost for any period o	lumn D. Reans, or used for	ıl estate tax r purposes	applicable to arother than long	ny portion	of the nursing
	(A)		(B)			(C)		(D)
	Tax Index N	<u>umber</u>	Property Descr	<u>iption</u>		Total Tax	_	Tax Applicable to ursing Home
1.	09-18-301-002		Long Term Care Prop	erty	\$	33,921.56	\$	33,921.56
2.					\$		\$	
3.					\$		\$	
4.					\$		\$	
5.					\$		\$	
6.					\$		\$	
7.					\$		\$	
8.					\$		\$	
9.					\$		\$	
10.					\$		\$	
				TOTALS	\$	33,921.56	\$	33,921.56

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES

NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. <u>Tax Bills</u>

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

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HFS 3745 (N-4-99)

IMPORTANT NOTICE

Jacksonville Skld Nur & Reh

FACILITY NAME

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

	IEIT I TUINE SE	id I (d) de Iten		111018411
FAC	ILITY IDPH LICENSE NUMBER	0051433		
CON	TACT PERSON REGARDING TH	IIS REPORT Steve Lavenda		
TEL	EPHONE (847) 236 - 1111	FAX	#: (847) 236 - 1155	
A.	Summary of Real Estate Tax Co	<u>st</u>		
	Enter the tax index number and reacost that applies to the operation of home property which is vacant, remembered in Column D. Do not include	f the nursing home in Column Dated to other organizations, or us	e. Real estate tax applicable sed for purposes other than	e to any portion of the nursing
	(A)	(B)	(C)	(D)
1.	<u>Tax Index Number</u>	Property Description	<u>Total Tax</u> \$	Tax Applicable to Nursing Home \$
2.			\$	\$
3			\$	\$

HFS 3745 (N-4-99)

COUNTY Morgan

4		\$	\$
5.		\$	\$
5		\$	\$
7		\$	\$
3.		\$	\$
9.		\$	\$
0.		\$	\$
	TOTALS	\$	<u> </u>
Real Estate Tax Cost Allocatio	<u>ns</u>		
Does any portion of the tax bill a	apply to more than one nursing home, vaca	ant property, or p	operty which is not directly

В.

Does any portion of the tax bill apply	to more than one nursing ho	me, vacant pro	operty, or property	which is not directly
used for nursing home services?	YES	NO		

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Page 10B

	ity Name & ID Number Jacksonville JILDING AND GENERAL INFORM			# 0051433	Report Period Beginnin	g: 01/01/13 Ending: 12/31/13
А. В.	Square Feet: 26,061		Exterior N	Masonry	Frame Steel	Number of Stories 1
C.	Does the Operating Entity?	(a) Own the Facility	(b) Rent from a	Related Organization	n.	(c) Rent from Completely Unrelated Organization.
	(Facilities checking (a) or (b) must of	complete Schedule XI. Those checking ((c) may complete Schedule	e XI or Schedule XII	-A. See instructions.)	G .
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipm	nent from a Related (Organization.	X (c) Rent equipment from Completely Unrelated Organization.
	(Facilities checking (a) or (b) must c	complete Schedule XI-C. Those checking	ng (c) may complete Sched	lule XI-C or Schedul	e XII-B. See instructions.	_
E.	(such as, but not limited to, apartme	d by this operating entity or related to ents, assisted living facilities, day trainiquare footage, and number of beds/uni	ing facilities, day care, ind	ependent living facili		
F.	Does this cost report reflect any org If so, please complete the following:	anization or pre-operating costs which	are being amortized?		YES	X NO
			G .	2. Number of Years C	YES Over Which it is Being An	
1.	If so, please complete the following:		2	2. Number of Years C		
1.	If so, please complete the following: Total Amount Incurred:	Nature of Costs:	2	I. Dates Incurred:	Over Which it is Being An	
1. 3.	If so, please complete the following: Total Amount Incurred: Current Period Amortization:		2	I. Dates Incurred:	Over Which it is Being An	
1. 3.	If so, please complete the following: Total Amount Incurred:	Nature of Costs:	2 tailing the total amount of	I. Dates Incurred:	Over Which it is Being An	
1. 3.	If so, please complete the following: Total Amount Incurred: Current Period Amortization:	Nature of Costs: (Attach a complete schedule de	2	l. Dates Incurred: f organization and pi	Over Which it is Being An	
1. 3.	If so, please complete the following: Total Amount Incurred: Current Period Amortization: OWNERSHIP COSTS:	Nature of Costs: (Attach a complete schedule de	2 tailing the total amount of	I. Dates Incurred: f organization and programme of the state of the s	Over Which it is Being And Pre-operating costs.)	

STATE OF ILLINOIS

Page 11

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

12/31/13 01/01/13 Ending:

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	D. Dullul	ing and Improvement Costs-Including F	1 2	1. (See Histract	4	1 5	6	1 7	8	9	$\overline{}$
	-	FOR BHF USE ONLY	Year	Year	•	Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7 8
8	Impr	ovement Type**									
9	Impr	устене турс					I	I			9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

^{*}Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\neg
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58 59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12F & 12G)						<u> </u>		67
68 Related Party Allocations (Pages 12H & 12I)								68
69 Financial Statement Depreciation			100,717			(100,717)		69
70 TOTAL (lines 4 thru 69)		\$	\$ 100,717		\$	\$ (100,717)	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Page 12B 01/01/13 Ending: 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$	\$ 100,717		\$	\$ (100,717)	\$	1
2 Monument Sign	2011	4,000		20	200	200	600	2
3 Shades	2011	10,327		20	516	516	1,549	3
4 Monument Sign	2011	3,687		20	184	184	553	4
5 9Ct Heat/Cool Units	2011	6,007		20	300	300	901	5
6 Data Cabling	2011	6,405		20	320	320	961	6
7 Lobby Installed Flooring & Fixtures; Preped & Painted Wall	2012	448,108		20	22,405	22,405	44,811	7
8 Main Dining Room Installed Flooring, Wallcoverings, Cabinets, Co	2012			20				8
9 Auxiliary Dining Room Installed Flooring, Fixtures, & Faucet; Pre	2012			20				9
10 Physical Therapy Room Installed Flooring, Fixtures, Wallcovering	2012			20				10
11 Corridors: Preped & Painted Walls, Installed Vinyl Flooring	2012			20				11
12 14 Resident Rooms Patch Walls, Painted & Installed Vinyl Flooring	2012			20				12
13 Beauty Shop Installed New Hair Wash Sink, Faucet, Hose, Light F				20				13
14 Administrative Office Installed New Carpet, 4 New Fixtures, Reloc	2012	(050		20	2.42	242	2.42	14
15 Installed New Water Heater & Circulator Pump	2013	6,850		20	343	343 173	343 173	15
16 Installed Trunk Line With New Circuits	2013 2013	3,458 9,657		20 20	173 483	483	483	16
17 Fire Sprinkler Repair 18	2013	9,037		20	403	463	465	18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 498,498	\$ 100,717		\$ 24,925	\$ (75,792)	\$ 50,373	34

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12C 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3		4	5	6	7	8	9	
	Year			Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$	498,498	\$ 100,717		\$ 24,925	\$ (75,792)	\$ 50,373	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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17									17
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19									19
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22									22
23									23
24 25									24 25
									25
26 27								_	26 27
28									28
29									29
30									30
31									31
32									32
33								 	33
34 TOTAL (lines 1 thru 33)		\$	498,498	\$ 100,717		\$ 24,925	\$ (75,792)	\$ 50,373	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Page 12D 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 498,498			\$ 24,925	\$ (75,792)	\$ 50,373	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13 14								13 14
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16								16
17								17
18				1				18
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27								27
28								28
29								29
30								30
31								31
32 33				 	-			32 33
		\$ 498,498	8 \$ 100,717		e 24 025	\$ (75,792)	\$ 50,373	34
34 TOTAL (lines 1 thru 33)		 \$ 498,498	3 \$ 100,717		\$ 24,925	(75,792)	§ 50,373	

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building and Improvement Costs-Including Fixed Equipmen	3	4	5	6	7	8	9	$\overline{}$
	Year	•	Current Book	Life	Straight Line	Ü	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 498,498	\$ 100,717	III I Cuits	\$ 24,925	\$ (75,792)	\$ 50,373	1
2		170,170	Ψ 100,717		21,023	(13,172)	30,272	2
3								3
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8 9								9
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 498,498	\$ 100,717		\$ 24,925	\$ (75,792)	\$ 50,373	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building and Improvement Costs-Including Fixed Equipmen	1. (See Histract	10115.) Kounu an numi	5	6	7	8	0	
1	Year	7	Current Book	Life	Straight Line	0	Accumulated	•
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	•
1 D 'LL' - Comment Laformet' -		\$	e Depreciation	III I Cars	e Depreciation		\$	1
1 Building Company Information		3	3		3	3	D	2
2 Buildings:								
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
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28								28
29								29
30								30
31								31
32								32
33								33
34								34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building and Improvement Costs-Including Fixed Equipmen	11. (See Histi uci	10115.) Kounu an numi	5	6	1 7	<u> </u>	9	
1	Year	7	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Building Company Information Continued	4	\$	© Depreciation	III I Cars	© Depreciation		\$	1
2 Building Company Information Continued		J .	J		J	Ф	3	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

Page 12H 01/01/13 Ending: 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building and Improvement Costs-Including Fixed Equipmen	11. (See Histi uci	10115.) Kounu an numi	5	6	1 7	<u> </u>	9	
1	Year	7	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
	4	\$	e	III I Cars	S Depreciation		\$	+-
1 Related Party Information		3	3		J	Ф	3	2
2 Buildings:								
3								3
4								4
5								5
6								6
7								7
8 Leasehold Information								8
9								9
10								10
11								11
12								12
13								13
14								14
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27								27
28								28
29								29
30								30
31								31
32					_			32
33								33
34								34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Report Period Beginning:

01/01/13 Ending:

Page 12I 12/31/13

Facility Name & ID Number Jacksonville Skld Nur & Reh XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	$\neg \neg$
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Related Party Information Continued		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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12								12
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24								24
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26								26
27								27
28								28
29								29
30								30
31								31
32 33								32
		•	<u> </u>		6	\$	e	
34 TOTAL (12H & 12I lines 1 thru 33)		\$	Э		\$	3	\$	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 132,558	\$	\$ 13,256	\$ 13,256	10	\$ 38,356	71
72	Current Year Purchases	18,425		1,842	1,842	10	1,842	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 150,982	\$	\$ 15,098	\$ 15,098		\$ 40,199	75

D. Vehicle Costs. (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 649,480	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,717	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,023	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (60,694)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 90,572	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	S	S	S	91

SEE ACCOUNTANTS' COMPILATION REPORT

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

8. List separately any amortization of lease expense included on page 4, line 34.		Fiscal Ye	ar Ending	Annual Rent	
This amount was calculated by dividing the total amount to be amortized					
by the length of the lease .		12.	/2014	\$	
		13.	/2015	\$	
9. Option to Buy: YES NO Terms:	*	14.	/2016	\$	
					
B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)					
15. Is Movable equipment rental included in building rental?	YES X NO				

Description: See Attached Schedule

C. Vehicle Rental (See instructions.)

16. Rental Amount for movable equipment: \$

	1	2		3		4	
		Model Year	N	Monthly Lease	I	Rental Expense	
	Use	and Make		Payment		for this Period	
17	Facility	2012	\$	869.00	\$	9,559	17
18							18
19							19
20							20
21	TOTAL		\$	869.00	\$	9,559	21

6,623

SEE ACCOUNTANTS' COMPILATION REPORT

(Attach a schedule detailing the breakdown of movable equipment)

HFS 3745 (N-4-99)

^{*} If there is an option to buy the building, please provide complete details on attached schedule.

^{**} This amount plus any amortization of lease expense must agree with page 4, line 34.

Jacksonville Skld Nur & Reh

0051433

Report Period Beginning:

Page 15

12/31/13 01/01/13 Ending:

XIII.	EXPENSES REL	ATING TO C	ERTIFIED	NURSE AIDE	(CNA)) TRAINING PROGRAMS	(See instructions.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)
--

1. HAVE YOU TRAINED CNAS	YES	2. CLASSROOM PORTION:	 3.	CLINICAL PORTION:
DURING THIS REPORT PERIOD?	X NO	IN-HOUSE PROGRAM		IN-HOUSE PROGRAM
If "ves" places complete the name index		IN OTHER FACILITY		IN OTHER FACILITY
If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY COLLEGE		HOURS PER CNA
explanation as to why this training was not necessary.		HOURS PER CNA		

B. EXPENSES

ALLOCATION OF COSTS

(d)

Facility Completed **Drop-outs** Contract **Total** 1 Community College Tuition 2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages **(b)** 5 In-House Trainer Wages (c) 6 Transportation **Contractual Payments CNA Competency Tests** TOTALS SUM OF line 9, col. 1 and 2 (e)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

S	
Ψ	

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 16 01/01/13 Ending: 12/31/13

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

2 5 6 Schedule V Staff **Outside Practitioner** Supplies Units of (other than consultant) (Actual or) Service Line & Column Cost **Total Units Total Cost** (Col. 3 + 5 + 6)Reference Service Units Cost Allocated) Column 2 + 4)**Licensed Occupational Therapist** 39 - 03 302,379 302,379 hrs **Licensed Speech and Language Development Therapist** 2 39 - 03 hrs 137,676 137,676 **Licensed Recreational Therapist** hrs 3 **Licensed Physical Therapist** 4 39 - 03 hrs 304,940 304,940 Physician Care 5 visits 6 **Dental Care** visits **Work Related Program** hrs 8 Habilitation hrs # of 39 - 02 114,183 114,183 9 **Pharmacy** prescrpts **Psychological Services** (Evaluation and Diagnosis/ **Behavior Modification**) 10 hrs 11 **Academic Education** hrs Other (specify): 12 13 Other (specify): See Supplemental 56,131 44,527 100,658 13 14 TOTAL 959,836 801,126 158,710

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Jacksonville Skld Nur & Reh XV. BALANCE SHEET - Unrestricted Operating Fund.

0051433 As of 12/31/13

Report Period Beginning: (last day of reporting year) 01/01/13 **Ending:**

This report must be completed even if financial statements are attached.

	This report must be completed even	1	perating	2 After Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	1,000	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		1,207,256		3
4	Supply Inventory (priced at)		38,408		4
5	Short-Term Investments				5
6	Prepaid Insurance				6
7	Other Prepaid Expenses		6,049		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,252,713	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost				14
15	Leasehold Improvements, at Historical Cost		496,829		15
16	Equipment, at Historical Cost		178,462		16
17	Accumulated Depreciation (book methods)		(142,341)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): See Attached Schedule		568,158		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	1,101,108	\$	24
25	TOTAL ASSETS	•	2 252 921	ø	25
25	(sum of lines 10 and 24)	\$	2,353,821	\$	25

		1 O _I	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	10,606	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		69,654		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Attached Schedule		240,246		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	320,506	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	320,506	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	2,033,315	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	2,353,821	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Jacksonville Skld Nur & Reh
XVI. STATEMENT OF CHANGES IN EQUITY

0051433

Report Period Beginning: 01/01/13

Ending: 12/31/13

	HANGES IN EQUITY		1	1
			Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1,188,668	1
2	Restatements (describe):			2
3	Rounding		4	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	1,188,672	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		844,643	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	844,643	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	2,033,315	24

^{*} This must agree with page 17, line 47.

01/01/13 **Ending: Report Period Beginning:**

0051433 XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272			1	
1 Gross Revenue All Levels of Care \$ 4,236,150 2 Discounts and Allowances for all Levels 1,159,866 3 SUBTOTAL Inpatient Care (line 1 minus line 2) \$ 5,396,016 B. Ancillary Revenue 4 Day Care 5 Other Care for Outpatients 6 Therapy 7 Oxygen 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) \$ 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 24 Contributions 25 Interest and Other Investment Income*** 7,272			Amount	
Discounts and Allowances for all Levels 1,159,866 3 SUBTOTAL Inpatient Care (line 1 minus line 2) \$ 5,396,016		A. Inpatient Care		
3 SUBTOTAL Inpatient Care (line 1 minus line 2) B. Ancillary Revenue 4 Day Care 5 Other Care for Outpatients 6 Therapy 7 Oxygen 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Supplies to Non-Patients 19 Laboratory 20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 24 Contributions 25 Interest and Other Investment Income*** 7,272	_		\$	1
B. Ancillary Revenue 4 Day Care 5 Other Care for Outpatients 6 Therapy 7 Oxygen 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272	2			2
4 Day Care 5 Other Care for Outpatients 6 Therapy 336,132 7 Oxygen 2,128 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) \$ 338,260 C. Other Operating Revenue 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 484 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income****	3		\$ 5,396,016	3
5 Other Care for Outpatients 6 Therapy 7 Oxygen 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 10 Other Medical Services 20 Radiology and X-Ray 318 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272				
6 Therapy 336,132 7 Oxygen 2,128 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) \$ 338,260 C. Other Operating Revenue 0 9 Payments for Education 10 10 Other Government Grants 11 11 CNA Training Reimbursements 12 12 Gift and Coffee Shop 484 13 Barber and Beauty Care 484 14 Non-Patient Meals 15 15 Telephone, Television and Radio 16 16 Rental of Facility Space 10,157 18 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 7,272	-			4
7 Oxygen 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 484 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 21 Other Medical Services 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272	5			5
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) C. Other Operating Revenue 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 3 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272	-			6
C. Other Operating Revenue 9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272				7
9 Payments for Education 10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272	8		\$ 338,260	8
10 Other Government Grants 11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272		C. Other Operating Revenue		
11 CNA Training Reimbursements 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income**** 7,272				9
12 Gift and Coffee Shop 13 Barber and Beauty Care 484 14 Non-Patient Meals 15 15 Telephone, Television and Radio 16 16 Rental of Facility Space 10,157 18 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 7,272	-			10
13 Barber and Beauty Care 484 14 Non-Patient Meals 15 15 Telephone, Television and Radio 16 16 Rental of Facility Space 10,157 18 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 19,905 D. Non-Operating Revenue 24 Contributions 7,272				11
14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272				12
15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 19,905 D. Non-Operating Revenue 24 Contributions 7,272	_		484	13
16 Rental of Facility Space 17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 24 Contributions 25 Interest and Other Investment Income*** 7,272				14
17 Sale of Drugs 10,157 18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 24 Contributions 25 Interest and Other Investment Income*** 7,272				15
18 Sale of Supplies to Non-Patients 19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 7,272 25 Interest and Other Investment Income*** 7,272				16
19 Laboratory 105 20 Radiology and X-Ray 318 21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)\$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272			10,157	17
20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272		* *		18
21 Other Medical Services 8,841 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)\$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272				19
22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)\$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272				20
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22 \$ 19,905 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272			8,841	21
D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 7,272				22
24 Contributions 25 Interest and Other Investment Income*** 7,272	23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,905	23
25 Interest and Other Investment Income*** 7,272				
				24
26 SURTOTAL Non-Operating Revenue (lines 24 and 25) \ 7 272	25		7,272	25
20 Sept of the fron-operating revenue (times 24 and 23) \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,272	26
E. Other Revenue (specify):****		E. Other Revenue (specify):****		
27 Settlement Income (Insurance, Legal, Etc.)		Settlement Income (Insurance, Legal, Etc.)		27
		1000		28
				28a
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$	29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 	29
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) \$ 5,761,453	30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,761,453	30

		Z		
	II. Expenses	Amour	ıt	
	A. Operating Expenses			
31	General Services	546,	273	31
32	Health Care	1,734,	282	32
33	General Administration	1,102,	278	33
	B. Capital Expense			
34	Ownership	379,	984	34
	C. Ancillary Expense			
35	Special Cost Centers	959,	836	35
36	Provider Participation Fee	194,	157	36
	D. Other Expenses (specify):			
37	• • • • • • • • • • • • • • • • • • • •			37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,916,	810	40
41	Income before Income Taxes (line 30 minus line 40)**	844,	643	41
1				
42	Income Taxes			42
42	NET INCOME ON LOSS BOD THE VEAD (! 44 ' ! ! 45)		(12	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 844,	643	43

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12/31/13

2

	III. Net Inpatient Revenue detailed by Payer Source		
	Medicaid - Net Inpatient Revenue	\$ 1,482,069	44
45	Private Pay - Net Inpatient Revenue	1,405,583	45
46	Medicare - Net Inpatient Revenue	2,455,839	46
	Other-(specify) HMO	57,226	47
48	Other-(specify) Insurance / Bedhold	(4,701)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,396,016	49

This must agree with page 4, line 45, column 4.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Does this agree with taxable income (loss) per Federal Income

Tax Return? Not Complete If not, please attach a reconciliation. See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

0051433

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

er me	enure reporun	g perioa.)		
	1	2**	3	4
	# of Hrs.	# of Hrs.	Reporting Period	Average

		1	2**	3	4				
		# of Hrs.	# of Hrs.	Reporting Period	Average				Nu
		Actually	Paid and	Total Salaries,	Hourly				of
		Worked	Accrued	Wages	Wage				Pa
1	Director of Nursing	1,737	1,996	\$ 78,843	\$ 39.50	1	1		Ac
2	Assistant Director of Nursing	824	831	18,660	22.45	2	35	Dietary Consultant	
3	Registered Nurses	6,939	7,415	160,332	21.62	3	36	Medical Director	Mon
4	Licensed Practical Nurses	25,714	27,638	527,286	19.08	4	37	Medical Records Consultant	
5	CNAs & Orderlies	59,604	63,594	642,258	10.10	5	38	Nurse Consultant	
6	CNA Trainees					6	39	Pharmacist Consultant	Mon
7	Licensed Therapist					7	40	Physical Therapy Consultant	
8	Rehab/Therapy Aides	2,845	3,047	40,218	13.20	8		Occupational Therapy Consultant	
9	Activity Director	1,793	1,991	21,365	10.73	9		Respiratory Therapy Consultant	
10	Activity Assistants	2,491	2,766	26,103	9.44	10		Speech Therapy Consultant	
11	Social Service Workers	2,104	2,352	49,735	21.15	11	44	Activity Consultant	
12	Dietician					12	45	Social Service Consultant	
13	Food Service Supervisor	2,032	2,211	27,002	12.21	13	46	Other(specify)	
	Head Cook					14	47		
15	Cook Helpers/Assistants	9,136	9,942	88,582	8.91	15	48		
	Dishwashers					16	1		
17	Maintenance Workers	1,933	2,136	25,955	12.15	17	49	TOTAL (lines 35 - 48)	
18	Housekeepers	5,492	5,944	59,849	10.07	18	1		-
19	Laundry	3,391	3,675	32,945	8.96	19	1		
20	Administrator	2,016	2,016	84,989	42.16	20	1		
21	Assistant Administrator					21	C. (CONTRACT NURSES	
22	Other Administrative					22	1		
23	Office Manager					23	1		Nu
24	Clerical	5,828	6,411	106,073	16.55	24	1		of
25	Vocational Instruction					25	1		Pa
26	Academic Instruction					26	1		Ac
	Medical Director					27		Registered Nurses	
28	Qualified MR Prof. (QMRP)					28		Licensed Practical Nurses	
	Resident Services Coordinator					29	52	Certified Nurse Assistants/Aides	
30	Habilitation Aides (DD Homes)					30			
31	Medical Records	1,553	1,736	32,478	18.71	31	53	TOTAL (lines 50 - 52)	
32	Other Health Care(specify)	ŕ	,	ŕ		32	1		
33	Other(specify) See Supplemental !	1,443	1,578	17,406	11.03	33	1		
	TOTAL (lines 1 - 33)	136,875	147,279	\$ 2,040,079 *	\$ 13.85	34	SEE AC	COUNTANTS' COMPILATION REF	PORT

B. CONSULTANT SERVICES

Report Period Beginning:

		1		2	3	
		Number	Total	Consultant	Schedule V	
		of Hrs.		Cost for	Line &	
		Paid &	F	Reporting	Column	
		Accrued		Period	Reference	
35	Dietary Consultant	192	\$	8,876	01-03	35
36	Medical Director	Monthly		12,000	09-03	36
37	Medical Records Consultant	8		251	10-03	37
38	Nurse Consultant					38
39	Pharmacist Consultant	Monthly		5,763	10-03	39
40	Physical Therapy Consultant					40
41	Occupational Therapy Consultant					41
42	Respiratory Therapy Consultant					42
43	Speech Therapy Consultant					43
44	Activity Consultant	48		3,087	11-03	44
45	Social Service Consultant	41		2,712	12-03	45
46	Other(specify)					46
47						47
48				•		48
49	TOTAL (lines 35 - 48)	289	\$	32,689		49

01/01/13

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

STATE OF ILLINOIS Page 21

	SIAIE	of Illinois		1 ago	5 4 1
Facility Name & ID Number Jacksonville Skld Nur & F	eh # 0051433	Report Period Beginning:	01/01/13	Ending:	12/31/13
XIX. SUPPORT SCHEDULES					

A. Administrative Salaries Ownership)		D. Employee Benefits and				F. Dues, Fees, Subscriptions and Promotion	ons	
Name				ription		Amount	Description		Amount		
Peggy Cawthon - 2/4/08-2/11/13	Administrator	0	\$_	5,923	Workers' Compensation		\$	74,847	IDPH License Fee	\$	
Jennifer Hubert - 2/11/2013	Administrator	0	_	79,066	Unemployment Compens	ation Insurance		50,563	Advertising: Employee Recruitment		1,763
					FICA Taxes			149,330	Health Care Worker Background Check		
					Employee Health Insurar	ce		86,847	(Indicate # of checks performed 167))	1,667
					Employee Meals				Patient Background Checks		
					Illinois Municipal Retirer	nent Fund (IMRF)*			License/Permit		1,810
					Dental & Vision Insurance	9		18	Advertising		37,862
TOTAL (agree to Schedule V, line 1	17, col. 1)	-	_	_	Employee Physicals/X-Ra	y	_	7,761	Dues & Subscriptions		2,704
(List each licensed administrator se	parately.)		\$	84,989	Group Life and Disability	Insurance		2,444	Allocated from Covenant Care		650
B. Administrative - Other			=		Other Employee Benefits			21,808			
					Physician Services			6,000	Less: Public Relations Expense	(
Description				Amount	Holiday Fund		_	792	Non-allowable advertising	-	(37,862)
Management Fees - Covenant Care	, Inc.		\$	179,610			_		Yellow page advertising	(
TOTAL (agree to Schedule V, line 1	· /		\$	179,610	Ine 22, col.8) E. Schedule of Non-Cash	Compensation Paid		400,410	TOTAL (agree to Sch. V, line 20, col. 8) G. Schedule of Travel and Seminar**		8,594
(Attach a copy of any management	service agreement)	_		to Owners or Employe	es					
C. Professional Services	-				7				Description		Amount
Vendor/Payee	Type			Amount	Description	Line#		Amount			
Sandberg, Phoenix & Von Gontard	Legal		\$	953			\$		Out-of-State Travel	\$	
Smartlink Solutions, LLC	Labor Managem	ent Softwar	e ¯	2,868							
Pinnacle Quality Insight	Customer Satisfa	ection		1,716							
National Datacare Corp.	Data Processing			2,700					In-State Travel		
Ability Network Inc	Network Service	S	_	554			_				
Accu-Med Services	MDS Software	_	_	2,656			_				
Sigmacare	Medical Records	Software		8,030			- -				
							_		Seminar Expense		105
									Allocated from Covenant Care, Inc.		26,317
			_						Entertainment Expense		
TOTAL (agree to Schedule V, line	19. column 3)		-		TOTAL		\$		(agree to Sch. V,	` —	
(If total legal fees exceed \$5,000, att		·s.)	\$	19,477			Ψ=		TOTAL line 24, col. 8)	\$	26,422
(11 total legal lees exceed \$5,000, att	aca copy of myore	.~•,	Ψ	-/91/1	* Attach copy of IMRE no	. • 60			**See instructions	Ψ	-0,122

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

HFS 3745 (N-4-99)

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year				Amount of Expense Amortized Per Year							
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jacksonville Skld Nur & Reh # 0051433 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13 XX. GENERAL INFORMATION: (1) Are nursing employees (RN,LPN,NA) represented by a union? No (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified Are there any dues to nursing home associations included on the cost report? in the Ancillary Section of Schedule V? Yes Yes If YES, give association name and amount. AHCA - \$1813, IHCA - \$1866 (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No Did the nursing home make political contributions or payments to a political For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach action organization? Yes If YES, have these costs a schedule which explains how all related costs were allocated to these functions. been properly adjusted out of the cost report? Yes Does the bed capacity of the building differ from the number of beds licensed at the (15) Indicate the cost of employee meals that has been reclassified to employee benefits end of the fiscal year? No If YES, what is the capacity? on Schedule V. Has any meal income been offset against N/A related costs? Indicate the amount. \$ N/A Have you properly capitalized all major repairs and equipment purchases? Yes What was the average life used for new equipment added during this period? (16) Travel and Transportation 10 Years a. Are there costs included for out-of-state travel? No Indicate the total amount of both disposable and non-disposable diaper expense If YES, attach a complete explanation. and the location of this expense on Sch. V. 21,235 b. Do you have a separate contract with the Department to provide medical transportation for Line **10-02** residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A Have all costs reported on this form been determined using accounting procedures c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14 consistent with prior reports? Yes If NO. attach a complete explanation. d. Have vehicle usage logs been maintained? Yes e. Are all vehicles stored at the nursing home during the night and all other Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. N/A times when not in use? Yes f. Has the cost for commuting or other personal use of autos been adjusted YES Are you presently operating under a sublease agreement? NO out of the cost report? g. Does the facility transport residents to and from day training? No Indicate the amount of income earned from providing such (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X If YES, please indicate name of the facility, transportation during this reporting period. \$ N/A IDPH license number of this related party and the date the present owners took over. (17) Has an audit been performed by an independent certified public accounting firm? No Firm Name: N/A (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department (18) Have all costs which do not relate to the provision of long term care been adjusted out during this cost report period. 194,157 This amount is to be recorded on line 42 of Schedule V. out of Schedule V? Yes (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services (12) Are there any salary costs which have been allocated to more than one line on Schedule V performed been attached to this cost report? for an individual employee? No If YES, attach an explanation of the allocation. N/A Attach invoices and a summary of services for all architect and appraisal fees.

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